(a) All prescriptions for Oxycodone HCl and Aspirin (more commonly known as Percodan), and Flurazepam (more commonly known as Dalmane);

(c) Anorexic drugs (amphetamine and amphetamine - like) may be dispensed with prior authorization for the diagnosed conditions of narcolepsy and minimal brain dysfunction in children, and

(d) Any injectable drugs on an ambulatory basis.

b. Dentures

(1) Dentures are limited to eligible EPSDT recipients.

(2) Dentures are limited to one (1) in five (5) years unless prior authorized.

(3) Relines are limited to two (2) in five (5) years unless prior authorized.

c. Prosthetic Devices

(1) Prosthetic devices are limited to items on the Durable Medical Equipment/Medical Supplies Procedure Codes and Price List except where prior authorized by the State Agency.

(2) Medical supplies and equipment in excess of specific limitations, i.e., cost, rental or lease equipment, or certain procedure codes must be prior authorized by the State Agency.

d. Eyeglasses

(1) This item includes lenses required to aid or improve vision with frame when necessary that are prescribed by a physician skilled in diseases of the eye or by an optometrist at the discretion of the patient.

(2) Eyeglasses are limited to one complete pair in a twenty-four (24) month period. Exceptions to this policy are:

(a) Recipients under twenty-one (21) years of age;

(b) Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter, and

(c) Broken or lost eyeglasses.

(3) Special glasses such as sunglasses and tints must be justified in writing by the ophthalmologist of optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

(4) Contact lenses must be prior authorized by the State Agency.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services, i.e., Other Than Those Provided Elsewhere in This Plan

a. Diagnostic services must be prior authorized.
b. Screening services are limited to eligible EPSDT recipients.
c. Rehabilitative services must be prior authorized and are described as follows:
   1) Rehabilitative services are intensive mental health services determined medically necessary for persons meeting Mobile Community Outreach Treatment Teams (MCOTT) Program Standards and all regulations governing the program as set forth in the D.C. Municipal Regulations. Participants will be evaluated at regular intervals to determine their ability to function in work, social and self-care role areas without requiring assistance from MCOTT and with high likelihood to maintain the functioning with less intensive intervention. Rehabilitative services are governed by an Interagency Agreement by and between the Office of the Receiver for the Commission on Mental Health Services in the Department of Human Services and the Medical Assistance Administration in the Department of Health. The Agreement sets forth the procedures for certifying MCOTT providers and for on-going review of provider performance. The Agreement also sets forth the financial arrangements between the parties for implementing MCOTT. The Agreement is available to the public at the Office of the General Counsel, Department of Health.

d. Preventive services must be prior authorized.

14. Services for individuals age 65 or older in institutions for Mental Diseases.

a. Inpatient hospital services are limited to services certified as medically necessary by the Peer Review Organization.
b. Skilled nursing facility services are limited to services certified as medically necessary by the Peer Review Organization.
c. Intermediate care facility services are limited to services certified as medically necessary by the Peer Review Organization.

15.a. Intermediate Care Facility Services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care are provided with no limitations.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions are provided with no limitations.

16. Inpatient Psychiatric Facility Services for individuals under 22 years of age are provided with no limitations.

17. Nurse Midwife Services are provided in accordance with D.C. Law 10-247.

18. Hospice Care (in accordance with section 1905(c) of the Act).

a. Hospice programs provide palliative care and counselling services to terminally ill individuals in accordance with a written plan of care for each individual. The initial Hospice election period shall be for ninety (90) days, followed by a second ninety(90) day period, a third period of thirty (30) days, and then one or more thirty (30) day extended election periods as long as the provider obtains a written certification statement that the recipient's medical prognosis is for a life expectancy of six months or less. This certification shall be obtained no later than two (2) calendar days after the beginning of each period.

b. An election to receive hospice care is considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the recipient remains in the care of the hospice and does not revoke the election.

c. If a recipient has both Medicare and Medicaid coverage, the hospice benefit shall be elected simultaneously as well as revoked simultaneously under both programs.

d. If the recipient revokes the hospice election, his or her waiver of other Medicaid coverage expires.

e. The recipient may revoke the hospice election during any period.

f. The recipient may designate a new provider of hospice care no more than once during an election period.

g. The recipient shall waive all rights to Medicaid coverage for the duration of the election of hospice care for services which are equivalent to the services covered under the Medicare Program. After Hospice election, Medicaid payment shall be made for services that are covered under the state plan if those services are not covered by Medicare.

1. Services provided by the designated hospice (either directly or under arrangement);

2. Services provided by the recipients' attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; and

3. Quality of life prescription drugs.

h. Covered hospice services include:

1. Nursing care provided by or under the supervision of a registered nurse;

2. Medical social services provided by a licensed social worker under the direction of a physician;

3. Services performed by a doctor of medicine, of dental surgery or dental medicine (for persons under 21 years of age), of podiatric medicine, or of optometry, except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine;

4. Counseling services, including bereavement, and if appropriate, spiritual and dietary;

5. Short-term inpatient care provided in a Medicaid certified hospice inpatient unit, or a Medicaid certified hospital or nursing home that provides supervision and management of the hospice team;

6. Durable medical equipment and supplies;

7. Prescription drugs which are used primarily for relief of pain and symptom control related to the recipient's terminal illness;

8. Physical, occupational and speech therapy services;

9. Home health aide, personal care aide, and homemaker services; and

10. Chemotherapy and radiation therapy to provide pain control or symptom relief.

i. Continuous Home Care - care to maintain a recipient at home during a brief period of crisis is covered for:

1. Nursing care, provided by either a registered nurse or a licensed practical nurse, and accounting for more than half of the period of care;

2. A minimum of eight (8) hours of care, not necessarily consecutive, provided during a twenty-four (24) hour day which begins and ends at midnight; and

3. Homemaker, home health, and personal care aide services if needed, to supplement the nursing care.

19. Case Management Services as Defined in, and to The Group Specified in, Supplement 1 to Attachment 3.1A (in accordance with section 1905(a) (19) or section 1915(g) of the Act) are ~~not~~ provided.

20. Extended Services for Pregnant Women

a. Pregnancy - related and postpartum services for 60 days after the pregnancy ends are provided with no limitations. The Department of Human Services will provide the full range of services available under the District of Columbia Medicaid State Plan, as long as the required medical service is pregnancy related.

JUN 29 1993

b. Services for any other medical condition that may complicate pregnancy are provided with no limitations. The Department of Human Services will provide the full range of services available under the District of Columbia Medicaid State Plan, as long as the required medical service is pregnancy related.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During A Presumptive Eligibility Period by A Qualified Provider (in accordance with section 1920 of the Act) is provided.

22. Respiratory Care Services (in accordance with section 1902(e)(9)(A) through (C) of the Act) are not provided.

22.1 Nurse practitioner services are provided in accordance with D.C. Law 10-247.

a. The services of the nurse practitioner are subsumed under the broad category, Advanced Practice Registered Nursing which includes, but is not limited to, nurse midwife, nurse anesthetist, nurse practitioner and clinical nurse specialist.

b. The services of the advanced practice registered nurse are to be carried out in general collaboration with a licensed health care provider.

23. Any Other Medical Care and Any Other Type of Remedial Care Recognized under State Law, Specified by the Secretary

a. Transportation services are not provided under this section of the state plan. See Attachment 3.1-D

b. Services of Christian Science Nurses are not provided.

c. Care and Services Provided in Christian Science Sanitoria are not provided.

d. Skilled Nursing Facility Services Provided for Patients under 21 Years of Age are provided with no limitations.

23. Any Other Medical Care and Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary (Cont'd)

e. Emergency Hospital Services

(1) The emergency room clinic physician encounter must be authenticated in the medical record by the signature of a licensed physician to be considered for reimbursement by the program.

(2) Reimbursement by the State Agency is restricted to one encounter when the same patient is seen in both the emergency room and/or outpatient clinic department on the same day.

(3) Reimbursement for induced abortions is provided only in cases where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy occurred as a result of rape or incest, and when the claim is accompanied by the following documentation:

i. Documentation that services were performed by a provider licensed to provide such services; and

ii. Written documentation from the treating physician that the life of the mother would be endangered if the fetus were carried to term; or

iii. Documentation that the pregnancy occurred as a result of rape or incest. For purposes of this requirement, documentation may consist of official reports; a written certification from the patient that the pregnancy occurred as a result of rape or incest; certification from the physician that the patient declared the pregnancy occurred as a result of rape or incest; or certification from the physician that in his or her professional opinion, the pregnancy resulted from rape or incest.

Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

f. Personal Care Services in Recipient's Home, Prescribed in Accordance with A Plan of Treatment and Furnished by A Qualified Person under Supervision of A Registered Nurse are provided with no limitations.

23 (continued) Any Other Medical Care and Any Other Type of Remedial Care Recognized under State Law, Specified by the Secretary

f Personal Care Services in Recipient's Home, Prescribed in Accordance with a Plan of Treatment, and Furnished by a Qualified Person under Supervision of a Registered Nurse are covered with limitations.

1 Personal care aide services must not exceed four (4) hours per day, or one thousand and forty (1,040) hours in any twelve (12) month period, unless prior authorization is given by the State Agency.

2 When the cost of PCA services, in addition to other home care services, exceeds the cost of institutional care over a six (6) month period, the State Medicaid Agency may limit or deny PCA services on a prospective basis.

3. Personal care aides may not be a member of the recipient's family. Family is defined as any person related to the recipient by blood, marriage, or adoption.

4. Covered Services

a. Section 1905 (a) (24) of the Act and Title 42, Code of Federal Regulations, section 440.170(f) authorizes the provision of personal care aide services in a recipient's home. Such services must be prescribed by a physician in accordance with the recipient's plan of treatment and be provided by an individual who is:
(1) Qualified to provide the services;
(2) Supervised by a registered nurse; and
(3) Not a member of the recipient's family.

b. Definitions

(1) "Personal Care Aide (PCA)" is an individual who provides services through a Provider Agency to assist the patient in activities of daily living, including bathing, dressing, toileting, ambulation, and eating.